

Patient Information

*First Name: _____

*Last _____

*Date of birth: _____

*Sex: Male Female

*Home address: _____

*Telephone: _____

_____ Alternate phone #: _____

*Will an interpreter be required? Yes No

Language: _____

Previous SickKids patient? Yes No

If yes, please provide:

Clinic and doctor name: _____

Medical Record Number (history number): _____

Health Card number: _____

Health Card version (*if applicable*): _____

Health Card province: _____

Health Card expiry date: _____

Parent/guardian information

Mother's name: _____

Father's name: _____

Mother's phone #: _____

Father's phone #: _____

Mother's address if different from patient:

Father's address if different from patient:

Note: Please indicate custodial parent, if applicable: Mother _____ Father _____

Guardian's name: _____

Guardian's phone #: _____

Alternate phone #: _____

Referring professional information

*First name: _____ *Last name: _____

*Professional designation : _____ (*please specify e.g. paediatrician, GP, PHN etc.*)

*Billing number (*if applicable*): _____

*Mailing address: _____

*Telephone: _____ *Fax: _____

E-mail address: _____ Is a Telehealth site available to you: Yes No